



**PHARMACY DEPARTMENT
CONSENT FORM FOR TREATMENT USING MEDICINE WITH ANIMAL ORIGIN**

SECTION A: PATIENT INFORMATION			
PATIENT NAME	IDENTITY CARD NUMBER	DEPARTMENT/WARD/UNIT	
	MRN NO.	GENDER	
		AGE	
SECTION B: PATIENT'S CONSENT STATEMENT			
I HAVE BEEN INFORMED BY THE DOCTOR AND UNDERSTAND THE USE OF THE MEDICATION AND TREATMENT THAT WILL BE GIVEN TO ME AS FOLLOWS:			PLEASE TICK (√)
1. The medication used for the treatment is derived from the animal origin as mentioned.			Yes <input type="checkbox"/> No <input type="checkbox"/>
2. The medication is an alternative to my treatment.			Yes <input type="checkbox"/> No <input type="checkbox"/>
3. I take full responsibility for all risks throughout the use of this medication and the treatment to be carried out.			Yes <input type="checkbox"/> No <input type="checkbox"/>
4. I have been given the opportunity to ask about the use of this medication in this treatment.			Yes <input type="checkbox"/> No <input type="checkbox"/>
SECTION C: TREATMENT INFORMATION			
NAME OF MEDICATION		ORIGIN OF ANIMAL	
RISK/SIDE EFFECT OF TAKING THE MEDICATION			
RISK OF NOT TAKING THE MEDICATION			
SECTION D: STATEMENT FROM SPECIALIST / MEDICAL OFFICER*			
I AM THE SPECIALIST / MEDICAL OFFICER* TREATING THIS PATIENT AND I HAVE EXPLAINED TO HIM/HER* OR THEIR NEXT OF KIN THE FOLLOWING:			PLEASE TICK (√)
1. The medication used for the treatment is derived from the animal origin which is _____			Yes <input type="checkbox"/> No <input type="checkbox"/>
2. The medication is an alternative to his/her* treatment.			Yes <input type="checkbox"/> No <input type="checkbox"/>
3. I will ensure that the use of this medication follows the established procedures throughout the treatment period.			Yes <input type="checkbox"/> No <input type="checkbox"/>
4. I have explained about their risk of taking this medication and given him/her* the opportunity to ask about the use of this medication in this treatment.			Yes <input type="checkbox"/> No <input type="checkbox"/>
SECTION E: ACKNOWLEDGEMENT BY SPECIALIST / MEDICAL OFFICER*			
I HAVE FULLY EXPLAINED TO THE PATIENT / NEXT OF KIN* THE USE AND RISKS OF THE MEDICATION THROUGHOUT THE COURSE OF TREATMENT.			
DOCTOR'S NAME	SIGNATURE AND OFFICIAL STAMP	IDENTITY CARD NUMBER	DATE
SECTION F: PATIENT / NEXT OF KIN* CONSENT			
I UNDERSTAND AND AGREE TO TAKE THE ABOVE MEDICATION THROUGHOUT THE COURSE OF TREATMENT.			
PATIENT / NEXT OF KIN NAME*	SIGNATURE	IDENTITY CARD NUMBER	DATE
SECTION G: WITNESSED BY			
NAME	SIGNATURE	IDENTITY CARD NUMBER	DATE
SECTION H: HEAD OF DEPARTMENT SIGNATURE			
SIGNATURE AND OFFICIAL STAMP			DATE

*Please delete whichever not applicable